

The Supreme Court's ACA Decision & its Implications for Medicaid

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Since it was signed into law in March 2010, the Patient Protection and Affordable Care Act (ACA) has been subjected to relentless litigation, with more than two dozen federal court cases filed so far. In *National Federation of Independent Business v. Sebelius (NFIB)*, the Supreme Court decided its first ACA case.¹ While potentially affecting the entire ACA, the case focused on two particular provisions: the individual mandate to have minimum essential coverage and the Medicaid Expansion. This paper provides an in-depth summary of the decision and detailed discussion of the implications of the decision for the Medicaid Expansion and the ACA's major public health provisions.² A table summarizing the holdings of the nine justices can be found on page 9 and a list of implications of the decision can be found on page 10-12.

The ACA is designed to accomplish comprehensive, market-based health reform. The law seeks to increase the number of insured Americans by requiring that those who can afford to do so purchase health insurance or pay a penalty (known as the minimum coverage provision or "individual mandate"). It provides for tax subsidies to enable individuals to purchase individual insurance policies, and facilitates the creation of Exchanges through which that insurance can be purchased. The ACA prohibits health insurers from discriminating on the basis of pre-existing conditions or from imposing lifetime limits on coverage. In addition, the law expands Medicaid coverage to individuals with incomes below roughly 133% of the federal poverty level.

The ACA also includes numerous provisions specifically targeted at population health. Chief among these initiatives is the Prevention and Public Health Fund, which was initially authorized to disburse \$15 billion over ten years.³ The ACA also authorizes funds for a number of smaller but still important programs, including community interventions that promote healthy lifestyles for individuals between the ages of 55-64, childhood anti-obesity projects, and

¹ 132 S. Ct. 2566 (2012). *NFIB* is the short-hand reference for the three appeals from the 11th Circuit: *National Federation of Independent Business v. Sebelius*, *Florida v. DHHS*, and *DHHS v. Florida*.

² This paper is part of a series of analyses on the ACA decision. See also Jane Perkins (NHeLP), *Summary of Supreme Court Decisions on the ACA* (June 29, 2012); Jane Perkins (NHeLP), *Overview to the Upcoming Supreme Court Decision on the ACA* (June 13, 2012), available from APHA.

³ 42 U.S.C. § 300u-11.

Community Transformation Grants to State, local, and tribal agencies for preventive health activities.⁴ In addition, the law authorizes funds for a number of discrete, evidence-based preventive services, as well as school-based health centers and oral health campaigns.⁵

The ACA also contains several provisions designed to improve public health through regulatory means. For example, it requires non-profit hospitals to conduct assessments of the health needs of the communities they serve and develop implementation plans to address those needs.⁶ It also requires that chain restaurants post information about the nutrition and caloric content of foods they sell and that some employers provide reasonable times and places for nursing mothers to nurse or express breast milk.⁷

Overview of the case

The Court heard *NFIB* on appeal from the Eleventh Circuit Court of Appeals. As noted by the Court, there was a split among the federal circuits regarding the constitutionality of the individual mandate provision. Both the Sixth and D.C. Circuits had upheld the mandate as a valid exercise of Congress's authority under the Commerce Clause.⁸ However, the Eleventh Circuit ruled the provision was not authorized by the Constitution's Commerce or Taxing Clauses.⁹

Over a three-day period from March 26-28, 2012, the Court heard six hours of arguments in the case—a modern day record. Over 140 *amicus* (friend of the court) briefs were submitted—an all-time record. The Court considered four questions:

- (1) Is the challenge to the individual mandate barred by the Anti-injunction Act?
- (2) Do the Commerce and/or Taxing Clauses of the Constitution authorize Congress to enact the individual mandate?

⁴ 42 U.S.C. §§ 300u-11, 300u-14, ACA § 4306. For more information, see Corey Davis, Network for Public Health Law, *Issue Brief: Public Health Provisions of the Protection and Affordable Care Act* (October 2011), available at http://www.networkforphl.org/_asset/x4mc6h/ACA-chart-formatted-FINAL.pdf.

⁵ 42 U.S.C.A. §§ 280h-4-5; 280k-1-3.

⁶ IRC § 501(r).

⁷ Patient Protection and Affordable Care Act, Pub. L. No. 111-148 §§ 4205, 4207 (Mar. 23, 2010).

⁸ See *Thomas More Law Ctr. v. Obama*, 651 F.3d 529 (6th Cir. 2011), *pet. for cert. denied*, __ S.Ct. __, 2012 WL 2470097 (June 29, 2012); *Seven Sky v. Holder*, 661 F.3d 1 (D.C. Cir. 2011), *pet. for cert. denied*, __ S.Ct. __, 2012 WL 2470101 (June 29, 2012).

⁹ See *Florida v. Sebelius*, 648 F.3d 1235 (11th Cir. 2011).

- (3) Does Congress have the power under the Constitution’s Spending Clause to authorize termination of all federal Medicaid funding to States that refused to expand Medicaid coverage to all individuals under 133% of the federal poverty level?
- (4) If the individual mandate is unconstitutional, is the entire ACA invalid or can all or part of the remaining law be “severed” and remain good law?

This paper focuses on the holdings on issues (2) and (3).¹⁰

The Court holds that the individual mandate is a valid exercise of Congress’s taxing power.

The parties disputed whether the individual mandate was a valid exercise of congressional authority under the Constitution’s Commerce Clause, Necessary and Proper Clause, and Taxing Clause. Before the decision was issued, commentators and the media had focused almost exclusively on the Commerce Clause argument. Indeed, at oral argument, the claim that the mandate is a permissible use of Congress’ tax authority was a secondary alternative for the federal government, representing only 217 lines in the voluminous transcript. In a surprise, however, the Court held that the individual mandate is a valid exercise of Congress’s power to tax.¹¹ This holding could and, perhaps should, have ended the matter; however, a majority of the Court also found Congress lacked authority to enact the individual mandate pursuant to the Commerce Clause.¹²

Legislating pursuant to the taxing power: In a part of the opinion joined by Justices Ginsburg, Breyer, Sotomayor, and Kagan, Chief Justice Roberts held the mandate is a valid exercise of Congress’s power to “lay and collect Taxes.” U.S. Const. Art. 1, § 8, cl. 1. They reached this conclusion despite the fact that the financial consequence imposed on an individual who does not purchase health insurance was labeled as a “penalty” in the ACA.

The Court concluded that, despite what Congress called it, the payment functions as a

¹⁰ As expected, in its first holding, the Court held that the Anti-Injunction Act (AIA) did not prevent it from determining the constitutionality of the individual mandate. This holding is the only unanimous decision in the case. 132 S. Ct. 2595-98. The AIA prohibits litigation to enjoin the collection of taxes, thus generally allowing taxes only to be challenged by persons who have paid the tax and then sued for a refund. The question was whether the “shared responsibility payment” that individuals must pay for ignoring the individual mandate is a tax within the meaning of the AIA. If a tax, then the AIA would bar a challenge because the penalty provision does not become effective until 2014. *Id.* at 2582-83. The Court concluded that Congress did not intend the penalty to be a tax within the meaning of the AIA. Since the Court upheld the constitutionality of the individual mandate, it did not reach the question of severability.

¹¹ This conclusion may seem at odds with the decision that the AIA does not apply. The opinion addresses the apparent contradiction by stating that, while nomenclature is significant for determining the applicability of the AIA, an Act of Congress, it is not definitive in determining whether an exaction is a tax or a penalty for constitutional purposes. Rather, the important question is the manner in which an exaction functions. *Id.*

¹² *Id.* at 2590-91.

tax: It is paid to the Treasury when taxpayers file their tax returns; it does not apply to individuals who do not pay federal income taxes; it is determined by familiar factors such as number of dependents, taxable income and joint filing status; it is found in the Internal Revenue Code and enforced by the IRS; and it produces revenue (expected to be about \$4 billion per year by 2017).¹³ The Court reasoned, as well, that the payment was not meant to be punitive, and the requirement to pay did not rest on the intent not to purchase insurance:

In distinguishing penalties from taxes, [the] Court has explained that ‘if the concept of penalty means anything, it means punishment for an unlawful act or omission.’ While the individual mandate clearly aims to induce the purchase of health insurance, it need not be read to declare that failing to do so is unlawful. Neither the Act nor any other law attaches negative legal consequences to not buying health insurance beyond requiring a payment to the IRS.¹⁴

The majority was not troubled by the fact that the individual mandate is intended to affect individual conduct, not just to raise revenue, noting that the use of taxes seeking to affect conduct is nothing new. For example, the substantial taxes imposed on the purchase of cigarettes are intended not just to raise money but also to encourage people to stop smoking.¹⁵ Thus, a majority concluded that the mandate is a constitutional use of Congress’s power to tax. It warned, however, that “Congress’s authority under the taxing power is limited to requiring an individual to pay money into the Federal Treasury, no more.”¹⁶

Legislating pursuant to the Commerce Clause and the Necessary and Proper Clause: As noted, given that the Court upheld the constitutionality of the mandate, it did not need to reach the question of whether the mandate could validly have been enacted pursuant to other Constitutional powers.¹⁷ Nevertheless, by a vote of 5-4, the Court stated the individual mandate was not valid under the Commerce Clause and could not be sustained under the Necessary and Proper Clause. This holding does not affect the ultimate outcome of the case, but does have implications for future legislation, as discussed below.

The Commerce Clause gives Congress the power to “regulate Commerce...among the several States.” U.S. Const. Art. I, § 8, cl. 3. Over the last 80 years, these words have been expansively interpreted to allow Congress to regulate not just interstate commerce itself, but

¹³ 132 S. Ct. at 2594.

¹⁴ *Id.* at 2597 (internal citations omitted).

¹⁵ *Id.* at 2596.

¹⁶ *Id.* at 2600.

¹⁷ For Chief Justice Roberts’ explanation of why he felt the need to address this issue, see 132 S. Ct. at 2600-01 (Part III.D.).

individual activities that, in the aggregate, “substantially affect” interstate commerce.¹⁸ In *NFIB*, however, the Court for the first time recognized a significant boundary on congressional authority. As expansive as cases construing the commerce clause power have been, the majority held that they uniformly describe the power as reaching only “activity.”¹⁹ In contrast, the majority held that the individual mandate is an attempt to regulate “inactivity,” i.e., the refusal to purchase health insurance.

The individual mandate ... does not regulate existing commercial activity. It instead compels individuals to *become* active in commerce by purchasing a product, on the ground that their failure to do so affects interstate commerce. Construing the Commerce Clause to permit Congress to regulate individuals precisely because they are doing nothing would open a new and potentially vast domain to congressional authority.²⁰

The majority also found that the individual mandate amounts to an attempt to exercise “police power,” which is exclusively vested in the States.²¹ Returning to the familiar broccoli example, the majority opinion posited that a decision allowing the mandate under the Commerce Clause would allow for legislation “ordering everyone to buy vegetables” to address the problem of unhealthy diets resulting in widespread obesity and increased health care costs.²² “This is not the country the Framers of our Constitution envisioned,” it said.²³ Because the individual mandate was an effort to regulate inactivity, it could not stand pursuant to the Commerce Clause.²⁴

From here, the majority easily concluded that the Necessary and Proper Clause did not apply. The Government argued that the individual mandate was a Necessary and Proper component of reforming the market for health care through insurance reforms such as guaranteed issue and community rating.²⁵ It found application of the Necessary and Proper Clause to be limited to laws that “involve exercises of authority derivative of, and in service to, a granted power.”²⁶ Because the individual mandate could not be upheld as a necessary and proper component of insurance reform under the Commerce Clause, the majority ruled, the Necessary

¹⁸ 132 S. Ct. at 2586.

¹⁹ *Id.* at 2587.

²⁰ *Id.* at 2587 (emphasis in original).

²¹ *Id.* at 2591.

²² *Id.* at 2588.

²³ *Id.* at 2589.

²⁴ *Id.* at 2590-91.

²⁵ *Id.* at 2581.

²⁶ *Id.*

and Proper clause would not have been able to save it.²⁷ Because the law was found valid under the taxing power, however, the conclusion about the Commerce and Necessary and Proper Clauses does not affect the outcome of this case.

Notably, the dissenting justices, Kennedy, Scalia, Alito, and Thomas, would have found the mandate unconstitutional and ruled that the entire ACA was invalid.²⁸

The Medicaid Expansion survives, but the Court holds that Congress did not have the power under the Spending Clause to authorize termination of all existing federal Medicaid funding to States that refuse to expand Medicaid as required by the ACA.

The Spending Clause of the Constitution, Art. I, § 8, cl.1, empowers Congress to tax and spend to provide for the “general welfare of the United States.” Congress has used this authority to address a number of issues on which it cannot directly legislate by offering federal funds to States in return for their agreement to abide by the standards set by the federal government as a condition of receiving the funding. Over the years, States have filed suits arguing that the conditions that Congress placed on receipt of federal funds were unduly coercive and therefore invalid. One of the most important cases on this issue was *South Dakota v. Dole*, a 1987 case in which the State argued that a Congressional requirement that States raise their drinking age to 21 or risk the loss of 5% of their federal highway funding allotment crossed the line into impermissible coercion.²⁹ The *Dole* Court rejected this argument, holding that such a condition was not unduly coercive because the States were free to reject the highway funds, even though such a choice would be unpleasant. The Court noted in passing, however, that “[o]ur decisions have recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which pressure turns into compulsion,” but that the financial inducement offered by Congress in that case did not rise to that level.³⁰

Indeed, until *NFIB*, no federal court (much less the Supreme Court) had found Congress’s exercise of Spending Clause authority to rise to the level of impermissible compulsion. The Supreme Court’s actions, both in agreeing to consider the question and finding the Medicaid Expansion and potential penalty beyond Congress’ spending authority, are unprecedented. It is also surprising that seven of the Justices agreed that the Expansion as written was unduly coercive, with only Justices Ginsburg and Sotomayor dissenting. Of equal interest is how a plurality of the Court, consisting of the Chief Justice and Justices Breyer and Kagan,

²⁷ *Id.* at 2593.

²⁸ *Id.* at 2652-77.

²⁹ 483 U.S. 203 (1987).

³⁰ 483 U.S. at 211 (internal quotations omitted).

crafted a remedy for the violation that gained the support of Justices Ginsburg and Sotomayor to form a 5-4 majority.

By a 7-2 margin, the Court accepted the argument that the ACA's requirement that States expand Medicaid to individuals with incomes below 133% of the federal poverty level (FPL) or risk loss of all of their federal Medicaid funding was unduly coercive. The ACA inserted the Expansion provision into the existing Medicaid statute, which includes a long-standing provision authorizing the Secretary of Health and Human Services (HHS) to terminate all federal Medicaid funding to a State that does not comply with a mandatory federal requirement, 42 U.S.C. § 1396c. Thus, the State plaintiffs argued, if they did not implement the Expansion, they would lose all of their Medicaid funds and, thus, as a practical matter, they had no choice but to participate.

Accepting this argument at face value without any evidence that States would actually be coerced, the majority opinion rests on three premises. First, according to plurality, the Medicaid Expansion “accomplishes a shift in kind, not merely degree. The original program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children.”³¹ Previous Medicaid amendments and expansions, such as those in the 1980s and 90s, concerned only these populations. By contrast, the ACA's Medicaid Expansion mandated inclusion of an entirely new group, an action that seven justices decided “transformed” Medicaid from a program serving designated population groups to “a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the federal poverty level.”³² The majority concluded that the Expansion made Medicaid “no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage.”³³

Second, the plurality found that States were being treated unfairly because they had inadequate notice that the new Expansion program would be a part of the Medicaid program when they agreed to participate in it.³⁴ Previous Supreme Court cases (that, notably, did not address coercion) have noted that Spending Clause programs are similar to contracts. Thus, Congress must establish clear notice of Spending Clause requirements so that States will know what they are agreeing to at the time that they agree to participate. According to the plurality opinion, when States first decided to participate in Medicaid, they did not foresee a requirement

³¹ 132 S. Ct. at 2605-06.

³² *Id.*

³³ *Id.*

³⁴ 132 S. Ct. at 2606.

to include everyone below a certain percentage of poverty.

Finally, likening the situation to “a gun to the head,” the plurality found that Congress was forcing the States to accept the unanticipated new program by threatening them with the loss of all federal funding for the old one.³⁵ “The threatened loss of over 10% of a State’s overall budget . . . is economic dragooning that leaves the States no real option but to acquiesce in the Medicaid Expansion.”³⁶ Notably, the plurality reached this conclusion despite the fact that provision that allows the Secretary of HHS to deny all or part of a non-compliant State’s federal Medicaid funding if it violates the terms of the Medicaid program has never been used to terminate the entirety of a State’s funding

The next question facing the Court was how to craft a remedy. A 5-member majority agreed to Chief Justice Roberts’ deft conclusion: The constitutional violation is “fully remed[ied]” by prohibiting the Secretary of HHS from terminating existing federal Medicaid funding of a State that does not implement the Expansion.³⁷ This is a carefully crafted holding that is intended to be narrowly construed:

Nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use. What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding.³⁸

Thus, the decision remedies the undue coercion by curbing the power of the federal government to enforce the Medicaid Expansion but maintains the ACA and the Medicaid Act in all other respects.

The following chart summarizes the vote count on each issue.

³⁵ *Id.* at 2604.

³⁶ *Id.* at 2605.

³⁷ *Id.* at 2607.

³⁸ *Id.*

Opinion of the Court				
Justice	Anti-Injunction Act	Individual Mandate-Taxing Power	Individual Mandate-Commerce Clause	Medicaid Expansion
Roberts	Does not apply	Constitutional	Unconstitutional	Unduly coercive, HHS cannot withhold all existing Medicaid funds for failure to implement
Scalia	Does not apply	Does not apply	Unconstitutional strike ACA	Unconstitutional strike ACA
Thomas	Does not apply	Does not apply	Unconstitutional strike ACA	Unconstitutional, strike ACA
Kennedy	Does not apply	Does not apply	Unconstitutional strike ACA	Unconstitutional, strike ACA
Alito	Does not apply	Does not apply	Unconstitutional strike ACA	Unconstitutional, strike ACA
Kagan	Does not apply	Constitutional	Constitutional	Unduly coercive, HHS cannot withhold all existing Medicaid funds for failure to implement
Sotomayor	Does not apply	Constitutional	Constitutional	Constitutional, as is penalty scheme
Ginsburg	Does not apply	Constitutional	Constitutional	Constitutional, as is penalty scheme
Breyer	Does not apply	Constitutional	Constitutional	Unduly coercive, HHS cannot withhold all existing Medicaid funds for failure to implement
Totals	9-0 No AIA Bar: Court may rule on Individual Mandate	5-4 Constitutional: Individual Mandate Survives	5-4 Individual Mandate could not be enacted under Commerce/Necessary and Proper Clauses	Medicaid Expansion survives , but HHS may not terminate funding for existing Medicaid program if State does not adopt Expansion

Based upon chart developed by Geo. Wash. Univ. Dep't of Health Pol. (July 2012).

Implications for Implementation of the Medicaid Expansion and Medicaid in General

Not surprisingly, the decision in *NFIB* is raising questions regarding implementation of various provisions of the ACA, particularly the Medicaid Expansion. Many of these will need to be addressed through policy clarifications from the White House and HHS. However, based upon our reading of *NFIB* and understanding of the ACA, we conclude that:

- The *NFIB* decision addresses *only* the Medicaid Expansion provisions contained in the ACA. Chief Justice Roberts summarizes these provisions as follows:

The Medicaid provisions of the Affordable Care Act ... require States to expand their Medicaid programs by 2014 to cover all individuals under the age of 65 with incomes below 133 percent of the federal poverty line. . . . The Act also establishes a new “[e]ssential health benefits” package, which States must provide to all new Medicaid recipients The Affordable Care Act provides that the Federal Government will pay 100 percent of the costs of covering these newly eligible individuals through 2016. . . . In the following years, the federal payment level gradually decreases, to a minimum of 90 percent.³⁹

- The enhanced federal matching provisions of the ACA are not affected by the decision. States that implement the Medicaid Expansion will receive historically generous federal funding: 100% federal funding for services provided to newly eligible beneficiaries, to be phased to 90% over time. This compares with, on average, 57% federal funding for most Medicaid services.
- All States, regardless of whether they implement the Medicaid Expansion, must comply with all mandatory provisions of the Medicaid Act or risk losing all federal funding. As Justice Roberts, writing for the majority, made clear, “Nothing in our opinion precludes Congress from . . . requiring that states accepting such funds comply with the conditions on their use.”⁴⁰ Thus, for example, the requirement that Medicaid payments for services provided by Federally Qualified Health Centers (FQHCs) equal the reasonable average costs of furnishing those services remains in full effect.⁴¹
- *NFIB* does not authorize States to receive the higher federal match for implementing less than the full Medicaid Expansion. The Medicaid Act still requires States to cover “all individuals” with incomes below 133% of the poverty line by January 1, 2014.⁴² Thus the

³⁹ 132 S.Ct. at 2601.

⁴⁰ *Id.* at 2607.

⁴¹ 42 U.S.C. § 1396a(bb)(2), (3).

⁴² 42 U.S.C. § 1396a(a)(10)(i)(VIII).

law does not allow a State to implement the Medicaid Expansion to any other level and receive the higher federal match available for the Expansion population. It is possible that the Secretary of HHS could use her authority under section 1115 of the Social Security Act to allow a State to “waive” core Medicaid requirements and allow States to extend Medicaid coverage to a level below 133% of the federal poverty level. But, such projects only allow the Secretary to waive certain provisions of the Medicaid Act to allow States to authorize “experimental, pilot, or demonstration” programs to test new service delivery methods. It is not clear what would be tested by such a project because the Secretary has already allowed at least 18 States to cover the adult population covered by the Medicaid Expansion. Moreover, even if such an experimental purpose was identified, nothing in section 1115 or the Medicaid Act appears to allow the project to receive the more generous federal matching rate.

- Regardless of whether a State implements the Expansion, the ACA’s other newly added Medicaid provisions continue in full force and effect, including requirements for coverage of young adults leaving the foster care system, Medicare-Medicaid rate parity for primary care providers and options for expanding coverage of community-based services and supports for people with disabilities and the elderly.
- Regardless of whether a State implements the mandatory Medicaid Expansion, the ACA’s maintenance of effort (MOE) provision will continue to apply. This provision requires States to maintain their Medicaid eligibility as it stood on March 23, 2010, the date the ACA was enacted until “the State has an exchange approved by the Secretary.”⁴³ Despite this plain language, the Republican Governor’s Association has written to the Administration asking whether the MOE requirement is still in effect and whether they may expand their Medicaid program to a lower poverty threshold (e.g. 100% FPL) and still receive the enhanced federal match. Letter from Republican Governor’s Ass’n to President Barack Obama, July 10, 2012, <http://rgppc.com/medicaid-and-exchange-letter-2/>. The Administration has not yet responded.
- Regardless of whether a State implements the Medicaid Expansion, the modified adjusted gross income (MAGI) provisions for determining Medicaid eligibility will continue to apply. This new method for determining incomes for eligibility purposes, contained in ACA § 2002, applies to most categories of non-disabled children and adults under 65 even without the Medicaid Expansion.

⁴³ 42 U.S.C. § 1396a(gg).

- Needy people will be left without health insurance if States do not implement the Medicaid Expansion. Subsidies will be available through the Exchanges to help people with limited incomes to purchase health insurance beginning in January 2014. However, only those with incomes at or above 100% FPL or certain legal immigrants with incomes below 100% FPL who do not qualify for Medicaid due to their immigration status are eligible to receive subsidies. Uninsured people with incomes below the FPL will be left out in the cold.
- Congress maintains its authority to implement publicly funded health coverage expansions through the Spending Clause.

Potential Challenges to Implementation

Many questions remain to be answered about how the ACA will actually be implemented. The situation is complicated by the fact that new challenges may arise as implementation proceeds. These challenges may take the form of legislative attacks or existing or future lawsuits. Or, State officials may simply refuse to participate. Notably, a few State governors (including those in Florida, Louisiana, and Texas) have publicly stated that they do not intend to implement the Medicaid Expansion. Many others are taking a “wait and see” approach and are unlikely to make a final decision before the November elections.

As described above, the ACA includes many provisions designed to improve the public health. A number of these provisions have been, and may continue to be, threatened. Provisions that provide funding for public health initiatives have already come under attack both by opponents of the law and by ostensible supporters, including the Administration, as the federal government attempts to cut federal spending. The Prevention and Public Health Fund in particular has been repeatedly targeted. In February 2012, it was cut by one-third, and at the end of April the House voted to eliminate it entirely to pay for student loan interest rate reductions (though this bill did not become law). In addition, the President’s proposed 2013 budget contains an \$80 million reduction in the Community Transformation Grant program as well as reductions in other public health spending, including a complete elimination of the Preventive Health and Health Services Block Grant. Thus, regardless of which party controls Congress or the White House, federal public health sources are likely to be threatened.

Other provisions that do not rely upon appropriations, even those already in effect, may also be at risk. Shortly after the *NFIB* decision was announced, industry groups affirmed their intent to continue efforts to repeal the law and obstruct its implementation. For example, the National Council of Chain Restaurants declared that it “will continue to work to repeal the Affordable Care Act,” the National Retail Federation stated that it “will redouble [its] efforts to

repeal the law,” and the National Grocers Association declared that, “N.G.A. will redouble its efforts to minimize the impact and burdens on independent retail grocers by continuing to work closely with fellow members of the Employers for Flexibility in Healthcare Coalition to educate the administration on the important need for maximum flexibility in regulatory requirements.”⁴⁴ While these efforts may not result in the complete repeal of the ACA, they could achieve targeted results.

Indeed, these efforts are already bearing fruit. For example, in June, 2011 the Treasury Department acceded to an industry request that certain nonprofit hospital reporting requirements mandated by the ACA be made optional for tax year 2010.⁴⁵ Similarly, initial FDA guidance on the ACA’s menu labeling requirement indicated that it applied broadly.⁴⁶ After pushback from some businesses, however, the FDA released draft regulations that exempt retailers for whom food is an incidental business, like movie theatres, from the requirement.⁴⁷ Industry and other groups opposed to the law will continue to use the agency rulemaking process to attempt to water down some of the ACA’s requirements and delay their implementation.

Potential Litigation Challenges

The *NFIB* decision will not bring an end to litigation challenging the ACA. First, there are a number of pending ACA challenges that were stayed while the Court considered the Florida cases. Some of these involve questions that were not decided by the Supreme Court, such as claims that the ACA infringes religious freedoms and illegally establishes an independent Medicare payment advisory board. These cases will now move forward.

In addition, those who oppose the ACA may attempt to use *NFIB* to open the door to new legal theories for attacking the law. None of the ACA’s public health provisions were independently challenged in cases that survived to the appellate level, but that could change now that *NFIB* failed to result in complete eradication of the law. *NFIB* does not, however, appear to

⁴⁴ See The Shelby Report, Industry Responds to Ruling Upholding Healthcare Law, available at <http://www.theshelbyreport.com/2012/06/28/industry-responds-to-ruling-upholding-healthcare-law/> (last visited July 20, 2012).

⁴⁵ See IRS, Announcement 2011-37, Portion of Form 990 Schedule H Optional for Tax-Exempt Hospitals for Tax Year 2010, available at <http://www.irs.gov/pub/irs-drop/a-11-37.pdf>

⁴⁶ See FDA, Guidance for Industry: Questions and Answers Regarding the Effect of Section 4205 of the Patient Protection and Affordable Care Act of 2010 on State and Local Menu and Vending Machine Labeling Laws (August 2010), available at <http://www.fda.gov/food/guidancecomplianceregulatoryinformation/guidancedocuments/foodlabelingnutrition/ucm223408.htm>.

⁴⁷ See Nutrition Labeling of Standard Menu Items in Restaurants and Similar Retail Food Establishments, 76 Fed. Reg. 19192 (Apr. 6, 2011).

establish new legal precedent that would make it significantly more likely that challenges to the ACA's public health provisions would succeed. Many of these provisions are similar to previous and existing federal efforts to improve public health through appropriations or regulation. Moreover, they do not require individuals to engage in commerce and are much smaller in financial scale than either the individual mandate or the Medicaid Expansion.

As previously described, a five-justice majority upheld the individual mandate as a legitimate use of Congress' taxing authority. In doing so, the Court made clear that it is not constitutionally problematic when the first goal of a tax is to regulate conduct rather than raise revenue. As the Court noted, measures designed to regulate the sale of tobacco, marijuana and sawed-off shotguns have been upheld under the taxing power even though they are clearly regulatory in nature.⁴⁸ Other public health provisions in the ACA that rely on Congress' taxing authority – such as a new levy on tanning services – appear to be similarly conceived.

NFIB does not seem to suggest that public health funding provisions are more vulnerable to attack on the grounds that Congress did not have the power to enact them under the Spending Clause. Provisions of the ACA that make funds available to those that wish to use them for specific purposes - such as grants for school-based health centers and community prevention activities, as described above - are typical examples of permissible Spending Clause activities in that they offer federal funding to States in exchange for agreeing to comply with federal requirements.⁴⁹ They differ from the Medicaid Expansion in several key respects. As noted above, *NFIB* held that the Expansion was unduly coercive in part because the Expansion changed the terms of the States' Medicaid agreements with the federal government to such an extent that the States could no longer be said to have knowingly and voluntarily consented to them. In contrast, programs such as the Prevention and Public Health Fund and Community Transformation Grants are new programs and States would be applying for funds with full notice of the requirements for how those funds must be spent. The *NFIB* decision also relied upon the fact that the potential penalty for failing to adopt the Medicaid Expansion could amount to a loss of more than 10% of a State's budget. The potential of such a loss would therefore give a State "no real option but to acquiesce in the Medicaid Expansion."⁵⁰ In contrast, none of the ACA's public health funding grants or appropriations are anywhere near the size of a State's Medicaid budget.

⁴⁸ *NFIB*, 132 S.Ct. at 2596.

⁴⁹ *See, e.g.*, 42 U.S.C. §§ 300u-13, which provides for community transformation grants to State governments to engage in community prevention activities, and requiring grantees to submit detailed plans, participate in annual meetings, and develop models for replication of programs.

⁵⁰ 132 S. Ct. at 2603-2605.

Finally, it remains to be seen whether the Court's discussion of the Commerce Clause will lead to a significant limitation of Congress's power or whether, in light of the unique characteristics of the health care market and individual mandate, it will be interpreted narrowly. At this point, however, it appears that the decision in *NFIB* is unlikely to support a successful challenge to the ACA's public health provisions enacted under Congress' authority to regulate interstate commerce, such as those requiring menu labeling and sufficient break time for nursing mothers. In fact, the reasoning of the decision suggests that those requirements are the types of regulations that are permitted under Congress's authority to regulate interstate commerce.

As noted above, the majority held that, because the mandate regulates inactivity, it exceeds Congress's power under the Commerce Clause. In other words, the mandate did not regulate the manner in which individuals purchased insurance, but instead required individuals to purchase it, therefore forcing them to engage in commerce.⁵¹ It is difficult to characterize any of the ACA's other provisions in this manner. The difference can be illustrated as follows: the menu labeling provision requires operators of chain restaurants to include nutritional labeling. It does not, however, require anyone to open a restaurant and provide the required nutrition information; it simply regulates existing workplaces and venues in a manner similar to existing laws.⁵²

Conclusion

The Supreme Court's *NFIB* decision has left most of the ACA intact, including centerpiece provisions requiring individuals to have adequate insurance coverage and insurance companies to abandon pre-existing condition exclusions and lifetime caps on coverage, as well as all of the law's public health provisions. The Medicaid Expansion survives, although the federal government no longer has the power to withhold all existing Medicaid funds to compel States to participate in the Expansion. The battles over health reform are far from over, however. Most States will need to be convinced to expand their Medicaid programs to cover their neediest citizens. In addition, we can expect attacks through the legislature, the regulatory process, and the courts. What those challenges may be and whether they are successful remains to be seen.

For more information, contact: Jane Perkins, Corey Davis, or Sarah Somers, National Health Law Program, (919) 968-6308.

⁵¹ 132 S. Ct. at 2590.

⁵² See *Heart of Atlanta Motel v. U.S.*, 379 U.S. 241 (1964) (holding Congress had the power under the Commerce Clause to require private accommodations to comply with the Civil Rights Act of 1964 and serve individuals regardless of race); *U.S. v. Darby*, 312 U.S. 100 (1941) (holding Congress had power under Commerce Clause to regulate working conditions, upholding provisions of Fair Labor Standards Act).